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109TH CONGRESS
1ST SESSION

H. R. 4450

To require hospitals and ambulatory surgical centers to disclose charge-related information and to provide price protection for treatments not covered by insurance as conditions for receiving protection from charge-related legal actions.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 6, 2005

Mr. SESSIONS introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To require hospitals and ambulatory surgical centers to disclose charge-related information and to provide price protection for treatments not covered by insurance as conditions for receiving protection from charge-related legal actions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Hospital and ASC Price Disclosure and Litigation Protection Act of 2005''.

SEC. 2. PROTECTION FROM CERTAIN LEGAL ACTIONS PROVIDED TO HOSPITALS AND AMBULATORY SURGICAL CENTERS THAT COMPLY WITH CHARGE-RELATED REQUIREMENTS.

(a) IN GENERAL.—A charge-related legal action may not be brought by an individual—

(1) against a hospital, if the hospital—

(A) has met the charge-related disclosure requirements under paragraphs (1)(A) and (2)(A) of section 3(a), with respect to such individual;

(B) complies with the reporting and posting requirements under paragraphs (1)(A) and (3)(A) of section 3(b); and

(C) has entered into an agreement under paragraph (1) of section 3(c) with the individual and has met the terms of such agreement; and

(2) against an ambulatory surgical center, if the ambulatory surgical center—

(A) has met the charge-related disclosure requirements under paragraphs (1)(B) and (2)(B) of section 3(a), with respect to such individual;

(B) complies with the reporting and posting requirements under paragraphs (1)(B) and (3)(B) of section 3(b); and

(C) has entered into an agreement under paragraph (2) of section 3(c) with the individual and has met the terms of such agreement.

(b) CHARGE-RELATED LEGAL ACTION DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term ''charge-related legal action'' means any Federal or State legal action brought by an individual for any damages or other relief, with respect to the amount charged by a hospital or an ambulatory surgical center for a treatment (or course of treatment), sought against the hospital or ambulatory surgical center, respectively, regardless of the legal basis for the action, including a violation of the Internal Revenue Code of 1986, section 1867 of the Social Security Act (42 U.S.C. 1395dd), or any other Federal law, a breach of contract claim, a breach of good faith and fair dealing claim, or otherwise.

(2) EXCEPTION.—Such term does not include a State legal action for which the legal basis is a claim of liability of the hospital or ambulatory surgical

center created by a statute of the State in which the action is brought.

(c) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this Act and shall apply to actions brought on or after such day.

SEC. 3. CHARGE-RELATED REQUIREMENTS.

(a) CHARGE-RELATED DISCLOSURE TO INDIVIDUALS REQUIRED.—

(1) PRE-TREATMENT DISCLOSURE.—

(A) HOSPITAL DISCLOSURE REQUIREMENT.—Subject to paragraph (3) and for purposes of complying with section 2(a)(1)(A), the charge-related disclosure requirement of this subparagraph is that a hospital provide to an individual who is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition, the following (determined at the time of scheduling):

(i) STATEMENT REGARDING DISCOUNT PRICES.—The following statement: ''Prices for enrollees in group plans and medicare beneficiaries may be lower because individuals pooled together in groups are sometimes offered discounted prices.''.

(ii) ESTIMATED PRICES TO BE CHARGED.—The estimated price that the hospital will charge for the treatment (or course of treatment).

(iii) NETWORK PLANS AND MANAGED CARE PLANS PAYMENT RATE.—The rate of payment for the treatment (or course of treatment) to the hospital that has been negotiated by or on behalf of the hospital with the network plan or managed care plan that has the largest number of enrollees, without regard to cost-sharing.

(iv) MEDICARE PAYMENT RATE.—The rate of payment for the treatment (or course of treatment) applicable to the hospital under the medicare program, without regard to cost-sharing.

(B) AMBULATORY SURGICAL CENTER DISCLOSURE REQUIREMENT.—Subject to paragraph (3) and for purposes of complying with section 2(a)(2)(A), the charge-related disclosure requirement of this subparagraph is that an ambulatory surgical center provide to an individual who is scheduled to receive a treatment (or to begin a course of treatment) that is not

for an emergency medical condition, the following (determined at the time of scheduling):

(i) STATEMENT REGARDING DISCOUNT PRICES.—The statement described in subparagraph (A)(i).

(ii) ESTIMATED PRICES TO BE CHARGED.—The estimated price that the ambulatory surgical center will charge for the treatment (or course of treatment).

(iii) NETWORK PLANS AND MANAGED CARE PLANS PAYMENT RATE.—The rate of payment for the treatment (or course of treatment) to the ambulatory surgical center that has been negotiated by or on behalf of the ambulatory surgical center with the network plan or managed care plan that has the largest number of enrollees, without regard to cost-sharing.

(iv) MEDICARE PAYMENT RATE.—The rate of payment for the treatment (or course of treatment) applicable to the ambulatory surgical center under the medicare program, without regard to cost-sharing.

(2) POST-TREATMENT DISCLOSURE.—

(A) HOSPITAL DISCLOSURE REQUIREMENT.—Subject to paragraph (3) and for purposes of complying with section 2(a)(1)(A), the charge-related disclosure requirement of this subparagraph is that the hospital include with any bill that includes the charges for a treatment an itemized list of component charges for such treatment, including charges for drugs and medical equipment involved, as determined at the time of billing. With respect to each item included on such list, the hospital shall include the following:

(i) PRICES CHARGED.—The price that the hospital charged for each item.

(ii) NETWORK PLANS AND MANAGED CARE PLANS PAYMENT RATE.—The rate of payment for each item to the hospital that has been negotiated by or on behalf of the hospital with the network plan or managed care plan that has the largest number of enrollees, without regard to cost-sharing.

(iii) MEDICARE PAYMENT RATE.—The rate of payment for each item applicable to the hospital under the medicare program, without regard to cost-sharing.

(B) AMBULATORY SURGICAL CENTER REQUIREMENT.—Subject to paragraph (3) and for purposes of complying with section 2(a)(2)(A), the charge-related disclosure requirement of this subparagraph is that the ambulatory surgical center include with any bill that includes the charges for a treatment an itemized list of component charges for such treatment, including charges for drugs and medical equipment involved, as determined at the time of billing. With respect to each item included on such list, the ambulatory surgical center shall include the following:

(i) PRICES CHARGED.—The price that the ambulatory surgical center charged for each item.

(ii) NETWORK PLANS AND MANAGED CARE PLANS PAYMENT RATE.—The rate of payment for each item to the ambulatory surgical center that has been negotiated by or on behalf of the ambulatory surgical center with the network plan or managed care plan that has the largest number of enrollees, without regard to cost-sharing.

(iii) MEDICARE PAYMENT RATE.—The rate of payment for each item applicable to the ambulatory surgical center under the medicare program, without regard to cost-sharing.

(3) APPLICATION OF REQUIREMENT ONLY ON REQUEST IF THIRD-PARTY PRICE ARRANGEMENT EXISTS.—A hospital or an ambulatory surgical center is not required to provide the applicable information under paragraph (1) or (2) for a treatment (or a course of treatment) for which there exists a third-party price arrangement unless the individual involved requests such information on or after the time of scheduling and before the time of billing for the treatment.

(b) HOSPITAL PUBLIC REPORTING AND AVAILABILITY OF CHARGE-RELATED INFORMATION REQUIRED.—

(1) SEMIANNUAL REPORTING REQUIREMENTS.—

(A) FOR HOSPITALS.—For purposes of complying with section 2(a)(1)(B), the reporting requirement of this subparagraph is that, not later than 80 days after the end of each semiannual period described in subparagraph

(C), a hospital report to the Secretary the following data:

(i) The frequency with which the hospital performed each procedure selected under clause (i) or (ii) of paragraph (4)(A) in an inpatient or outpatient setting, respectively, during such period and the frequency with which the hospital administered a drug selected under clause (iv) of such paragraph in an inpatient setting during such period.

(ii) If such a procedure was so performed or such a drug was so administered during such period—

(I) the average charge billed by the hospital during such period for such procedure or drug in cases in which there did not exist a third-party price arrangement for such procedure or drug;

(II) the rate of payment during such period for such procedure or drug to the hospital that has been negotiated by or on behalf of the hospital with the network plan or man-

aged care plan that has the largest number of enrollees, without regard to cost-sharing; and

(III) the rate of payment during such period for such procedure or drug applicable to the hospital under the medicare program, without regard to cost-sharing.

(B) FOR AMBULATORY SURGICAL CENTERS.—For purposes of complying with section 2(a)(2)(B), the reporting requirement of this subparagraph is that, not later than 80 days after the end of each semiannual period described in subparagraph (C), an ambulatory surgical center report to the Secretary the following data:

(i) The frequency with which the ambulatory surgical center performed each procedure selected under clause (iii) of paragraph (4)(A) during such period.

(ii) If the procedure was so performed during such period—

(I) the average charge billed by the ambulatory surgical center during such period for such procedure in

cases in which there did not exist a third-party price arrangement for such procedure;

(II) the rate of payment during such period for such procedure to the ambulatory surgical center that has been negotiated by or on behalf of the ambulatory surgical center with the network plan or managed care plan that has the largest number of enrollees, without regard to cost-sharing; and

(III) the rate of payment during such period for such procedure applicable to the ambulatory surgical center under the medicare program, without regard to cost-sharing.

(C) SEMIANNUAL PERIOD DESCRIBED.—For purposes of this paragraph, a semiannual period described in this subparagraph is a period of six months beginning on January 1 or July 1, with the first such period beginning more than one year after the date of the enactment of this Act.

(2) PUBLIC POSTING OF INFORMATION.—The Secretary of Health and Human Services shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under paragraph (1). Such information shall be set forth in a manner that promotes charge comparison among hospitals and among ambulatory surgical centers.

(3) AVAILABILITY OF INFORMATION POSTED.—

(A) REQUIREMENT FOR HOSPITALS.—For purposes of complying with section 2(a)(1)(B), the posting requirement of this subparagraph is that, not later than the date of the enactment of this Act, a hospital prominently post at each admission site of the hospital—

(i) a notice of the availability of the information described in paragraphs (1)(A) and (2)(A) of subsection (a); and

(ii) a notice of the availability of the information reported under paragraph (1)(A) on the official public Internet site under paragraph (2).

(B) REQUIREMENT FOR AMBULATORY SURGICAL CENTERS.—For purposes of complying with section 2(a)(2)(B), the posting re-

quirement of this subparagraph is that, not later than the date of the enactment of this Act, an ambulatory surgical center prominently post at each admission site of the ambulatory surgical center—

(i) a notice of the availability of the information described in paragraphs (1)(B) and (2)(B) of subsection (a); and

(ii) a notice of the availability of the information reported under paragraph (1)(B) on the official public Internet site under paragraph (2).

(4) SELECTION OF PROCEDURES AND DRUGS.—For purposes of this subsection:

(A) INITIAL SELECTION.—Based on national data, the Secretary shall select the following:

(i) The 25 most frequently performed procedures in a hospital inpatient setting, as identified by diagnosis-related group.

(ii) The 25 most frequently performed procedures in a hospital outpatient setting, as identified under the classification system for covered OPD services under sec-

tion 1833(t)(2)(A) of the Social Security Act (42 U.S.C. 1395l(t)(2)(A)).

(iii) The 25 most frequently performed procedures in an ambulatory surgical center setting.

(iv) The 50 most frequently administered drugs in a hospital inpatient setting.

(B) UPDATING SELECTION.—The Secretary shall periodically update the procedures and drugs selected under subparagraph (A).

(c) CHARGE AGREEMENTS FOR UNINSURED TREATMENTS.—

(1) FOR HOSPITALS.—Subject to paragraph (3) and for purposes of complying with section 2(a)(1)(C), an agreement under this paragraph is an agreement entered into between a hospital and an individual, on or after the date of scheduling treatment involved for the individual and before the date of such treatment, that provides that the hospital will not charge for the treatment an amount that is greater than the price that has been agreed to by the hospital and the individual and specified in writing in such agreement.

(2) FOR AMBULATORY SURGICAL CENTERS.—Subject to paragraph (3) and for purposes of com-

plying with section 2(a)(2)(C), an agreement under this paragraph is an agreement entered into between an ambulatory surgical center and an individual, on or after the date of scheduling treatment involved for the individual and before the date of such treatment, that provides that the ambulatory surgical center will not charge for the treatment an amount that is greater than the price that has been agreed to by the ambulatory surgical center and the individual and specified in writing in such agreement.

(3) APPLICATION OF REQUIREMENT ONLY TO UNINSURED TREATMENTS.—Paragraphs (1) and (2) shall apply only with respect to a treatment (or course of treatment) for which there does not exist a third-party price arrangement.

(d) ADMINISTRATIVE PROVISIONS.—

(1) IN GENERAL.—The Secretary shall prescribe such regulations and issue such guidelines as may be required to carry out this section.

(2) FORM OF REPORT AND NOTICE.—The regulations and guidelines under paragraph (1) shall specify the following:

(A) FOR DISCLOSURE TO INDIVIDUALS.—The form and manner in which a hospital or an ambulatory surgical center shall provide the in-

formation under subsection (a)(1)(A) or (a)(1)(B), respectively.

(B) FOR PUBLIC REPORTING.—The electronic form and manner by which a hospital or an ambulatory surgical center shall report data under subsection (b)(1)(A) or (b)(1)(B), respectively.

(C) FOR PUBLIC POSTING.—The form in which a hospital or an ambulatory surgical center shall post notices under subsection (b)(3)(A) or (b)(3)(B), respectively.

(e) NON-PREEMPTION OF STATE LAWS.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure or posting of price, charge, or other information for a hospital or an ambulatory surgical center.

SEC. 4. DEFINITIONS.

In this Act:

(1) AMBULATORY SURGICAL CENTER.—The term ''ambulatory surgical center'' means an ambulatory surgical center described in section 1832(a)(2)(F)(i).

(2) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' has the mean-

ing given that term in section 1867(e)(1) of the Social Security Act (42 U.S.C. 1395dd(e)(1)).

(3) HOSPITAL.—The term ''hospital'' has the meaning given that term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(4) MEDICAID PROGRAM.—The term ''medicaid program'' means the program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is entitled to benefits under part A, and enrolled under part B, of the medicare program, and who is not enrolled in a Medicare Advantage plan under part C of such program.

(6) MEDICARE PROGRAM.—The term ''medicare program'' means the program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(8) STATE.—The term ''State'' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(9) THIRD-PARTY PRICE ARRANGEMENT.—The term ''third-party price arrangement'' means, with

respect to a treatment (or course of treatment) in a hospital or an ambulatory surgical center, a contract or other agreement between the hospital or the ambulatory surgical center, respectively, and a third party, including an arrangement—

(A) with a health maintenance organization plan, network plan, or managed care plan, or

(B) under the medicare or medicaid program,

that establishes the price or the maximum price of the treatment (or course of treatment) for beneficiaries under the plan or title.

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